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REDEFINING HHS INTERNATIONAL RESPONSE: CHALLENGES AND RECOMMENDATIONS FOR INTERAGENCY PARTNERSHIPS

BY

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USAWC CIVILIAN RESEARCH PROJECT

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ABSTRACT

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The world's population is growing by approximately 60 million people annually, estimated to reach eight billion by 2030; 95 percent of the increase is in the developing world. Where economic growth fails to support population increases, the potential for instability or war will be considerable. Lessons learned from stability operations (SO) in Afghanistan and Iraq have resulted in transformed U.S. national security strategies for an increased "whole of government" approach. In 2006, the Pandemic and All-Hazards Preparedness Act (PAHPA), established the Assistant Secretary for Preparedness and Response (ASPR) within the Department of Health and Human Services (HHS). PAHPA provided new authorities to HHS, directing the ASPR to "provide leadership in international programs, initiatives, and policies that deal with public health and medical emergency preparedness and response." The ASPR international role is developing. A recent RAND report called for U.S. Army's research institutes, such as the U.S. Army War College, to determine how civilian departments and agencies might contribute to a strategic vision for the interagency SO process. This research aims to shape recommendations and priorities for HHS action, fostering interagency partnering in SO.

REDEFINING HHS INTERNATIONAL RESPONSE: CHALLENGES AND RECOMMENDATIONS FOR INTERAGENCY PARTNERSHIPS

The world's population will continue to grow by approximately 60 million people annually, estimated to reach eight billion by about 2030, with the majority of the increase (95 percent) in the developing world. In countries where economic growth fails to keep up with population increases, the potential for instability or war will be considerable.[1] Lessons learned from military operations in Afghanistan, Iraq and the war on terrorism have resulted in the transformation of U.S. national security and defense strategies for an increased "whole of government" approach to stability operations (SO).[2]

The U.S. Government (USG) National Security Strategy (2006)[3] is a return to a more multilateral approach than the previous Strategy of 2002 and includes as one of its nine tasks a transformation of "…America's national security institutions to meet the challenges and opportunities for the 21st Century." This was reflected in then Secretary Rice's Transformational Diplomacy initiative and now with Secretary of State Hillary Clinton's philosophy of "soft power" and diplomacy to attain U.S. interests, as opposed to the threat of military power.[4,5]

The National Security Presidential Directive 44 (NSPD-44), Management of Interagency Efforts Concerning Reconstruction and Stabilization, was signed by President Bush in December 2005. The purpose of this Directive is to "promote the security of the United States through improved coordination, planning, and implementation for reconstruction and stabilization assistance for foreign states and regions at risk of, in, or in transition from conflict or civil strife".[6] NSPD-44 summarizes key roles and responsibilities of government agencies for SO, including the Department

of State (DoS), Executive Departments and Agencies of the USG, DoD and non-DoD agencies.[7] The Secretary of State is designated as the lead for management of interagency reconstruction and stabilization efforts. NSPD-44 thus sets the policy for interagency roles in conducting reconstruction and stabilization efforts, the first time any administration has implemented interagency policy focused on SO.[8,9]

In anticipation of NSPD-44, and in accordance with changes in the National Security Strategy described earlier, the DoD published DoD Directive (DoDD) 3000.05, Military Support for Stability, Security, Transition, and Reconstruction (SSTR) Operations, in November 2005. This Directive established the DoD's overall policy and assigned responsibilities within DoD for planning, training, and preparing to conduct and support SO. The Directive states that, "Stability operations are a core U.S. military mission that the Department of Defense shall be prepared to conduct and support. They shall be given priority comparable to combat operations and be explicitly addressed and integrated across all DoD activities…"[10] Furthermore, the Directive denotes that DoD will work closely with USG Departments and Agencies to support SSTR operations as military-civilian teams are vital in SO. DoDD 3000.05 is intended to enhance DoD capabilities and integrate the capabilities and capacities of the defense, diplomatic, and development communities, referred to as the "3 D's" of reconstruction and stabilization programs,[11] for achieving unity of effort in SO, with emphasis on integrating civilian and military efforts as keys to success. Ultimately, the intent is to strengthen interagency planning and enhance both DoD and non-DoD capabilities in SO.

The mission of the Department of Health and Human Services (HHS) is "protecting the health of all Americans and providing essential human services,

especially for those who are least able to help themselves".[12] The Pandemic and All-Hazards Preparedness Act (PAHPA) was passed in December 2006, Public Law No. 109-417, and amended the Public Health Service Act, creating the Assistant Secretary for Preparedness and Response (ASPR) within HHS. In the wake of Hurricane Katrina in August 2005, the Act attempts to more clearly delineate the roles and responsibilities of the Department of Homeland Security (DHS) and HHS. In addition, PAHPA authorized the ASPR to "provide leadership in international programs, initiatives, and policies that deal with public health and medical emergency preparedness and response."[13] This is reflected by the inclusion of the Emergency Support Function (ESF) #8: Public Health and Medical Response: International Programs as one of the major programs in the Act. The role of the ASPR in international response is under development, with an International Emergency Response Framework (IERF) presently underway to more clearly define the role of HHS engagement in international response and collaboration with USG Departments and Agencies that are currently active in this arena.[14]

A recent RAND report has called for the U.S. Army's research institutes, such as the U.S. Army War College, to engage in identifying how civilian departments and agencies might contribute to developing a strategic vision for the interagency process in SO.[15] This research paper will provide an historical review of DoD and civilian agency coordination in past SO and an analysis of current challenges of integrating the "whole of government" approach into international response. Shaping recommendations and priorities for action for HHS, to foster interagency partnering in international response, is the purpose of this report.

Historical Review

The U.S. has employed its armed forces several hundred times in what would now be categorized as SO, as early as the 1940s. Early on, the armed forces were used for post-conflict reconstruction in Germany and Japan. A retrospective look at World War II reveals that once Germany was defeated by Allied Forces, it was U.S. combat forces that initially performed security and humanitarian operations; they were on the ground at a time of critical need. In Japan, evidence of SO is illustrated by the deployment of an operational food distribution network.[16] U.S. post-conflict reconstruction in both Germany and Japan were extensive endeavors, attempting societal transformation, and considered successful; however, subsequent operations have not reached comparable levels.[17]

Stability operations were also conducted in both the Korean and Vietnam wars. In Korea, a program called the "Armed Forces Aid to Korea" provided emergency medical care to Korean civilians; educational programs for Korean medical personnel; and supplies, funds and technology for the construction of hospitals.[18] In Vietnam, military medical officers of the 3rd Marine Division operated a children's hospital, co-located with a Forward Casualty Receiving Facility near the Demilitarized Zone.

Precedents to modern SO with a more "whole of government" approach are also reviewed here. Since 1945, the United Nations (UN) has conducted 55 peace operations of which 80 percent started after 1989.[19] The U.S. has been involved in eight post-conflict R&S operations from 1990-2005. These operations occurred in Somalia, Rwanda, Haiti, Bosnia, Kosovo, Liberia, Afghanistan and Iraq.[20] Of significance is the cost of human lives and dollars of such activities, reported to exceed

that of combat operations.[21] Operations discussed in this paper will include Provide Comfort in Iraq (1991); Restore Hope in Somalia (1992-94); Support Hope in Rwanda (1994); and Restore Democracy in Haiti (1994-95).

The overall assessment of the U.S. military interactions with the humanitarian assistance community during Operation Provide Comfort in Iraq was considered successful.[22] On April of 1991, then President George Bush directed the U.S. military to assist the Kurds, who had rebelled against Saddam Hussein during the war in Iraq and subsequently, left their homes. The military was to assist with resettling the Kurdish refugees who had fled to southern Turkey, to temporary camps in northern Iraq and finally, back to their original villages. President Bush made it clear that the military mission was purely humanitarian relief.[23]

Several factors are cited for the successful partnering between the U.S. military and civilian agencies. First, the coordination between the two groups was decentralized and informal, which allowed for the development of trusted relationships and fostered information sharing. The military organized meetings with humanitarian assistance staff and shared risk assessments that became a focal point of coordination. In addition, the NGO (Non-Governmental Organization) Coordination Committee for Northern Iraq was created by the NGOs, which allowed for inter-NGO coordination; the U.S. Agency for International Development (USAID)/Office of Foreign Disaster Assistance (OFDA) was also in attendance at this forum. The Committee was located within one of the refugee camps. The OFDA staff lived in this camp as well, which reportedly enhanced the level of cooperation achieved.[24]

Although stereotypes existed between the two groups, individual interaction resulted in overcoming these barriers between the military officers who served as liaisons to the NGOs, and the NGO staff. It was stated that, “The officers did not behave as if they were “in charge””; this resulted in creating an optimal environment to foster civil-military communication and ultimately, provide the necessary humanitarian assistance to the Kurdish refugees.[25]

Unfortunately, the civil-military operations during Restore Hope in Somalia, which followed closely after the success in Provide Comfort, showed no progress in institutionalizing the lessons learned. Restore Hope, led by a U.S. multinational force, occurred from December 1992-May 1993. It is noted that although the military and humanitarian community worked together to distribute food and end the ongoing famine, the overall assessment of this operation was not positive. This lack of success is attributed to an unclear mission statement and absence of interagency and civil-military planning in the early stages of operations.[26]

In contrast to the favorable civil-military relationships and communication established during Provide Comfort, in Somalia, this was not the case, particularly during the planning phase of the operation. There was a lack of unity of command. The NGO community perceived that the military was uninterested in working with them and was withholding information necessary to maximize their effectiveness, whereas the military viewed its primary role as providing security rather than humanitarian relief.[27] The experience in Somalia overall is considered a failed intervention, with ineffective civil-military engagement.

In 1994, war broke out between the Tutsi and Hutu tribes in Rwanda, resulting in millions of refugees in surrounding countries. In this instance, civil-military lessons learned from Somalia may have played a role in the ultimate success of Operation Support Hope.[28] A U.S. military Joint Task Force (JTF) was directed by then President Clinton to assist humanitarian organizations in relief operations, under the direction of the UN High Commission on Refugees (UNHCR). The U.S. military and in particular, the JTF Commander, clearly recognized that the military's role was in support of the larger UN mission and that the military was not in charge. In addition, the military officer in charge of civil-military affairs consulted NGO/interagency expertise to identify needs. Three Civil-Military Operations Centers (CMOCs) were established, to coordinate support to the UNHCR and thus, the NGO/interagency community. Overall these operations were considered successful, as the military supported the needs of the NGO/interagency community under the direction of the UNHCR.[29]

Finally, the overall assessment of the execution of Operation Restore Democracy in Haiti in 1994, a UN sanctioned operation, is considered generally successful, although the interagency planning and coordination initially delayed delivery of effective humanitarian assistance. Even so, it is important to note that interagency planning was more integrated with the U.S. military than in any of the previous operations and a formal interagency political-military plan was developed in advance.[30,31]

A multinational force was deployed with their objective changing rapidly from one of providing humanitarian assistance to restoring democracy - reinstating President Aristide. Formal meetings were held between the DoS and InterAction, a coalition of humanitarian organizations providing relief worldwide, to establish roles prior to

deployment. However, the U.S. military was unable to share their plans with these organizations because the mission included permissive entry; thus, plans were classified.[32] Once collaboration was permitted, decisions were not effectively communicated between the organizations working in the field.[33]

Interagency planning began in earnest prior to deployment; however, DoD was reluctant to become involved in missions in Haiti. Finally, once the 10th Mountain Division began planning for their entry into Haiti, little coordination occurred between the military and civilian agencies. Lack of coordination at the strategic level translated down to initial operational ineffectiveness.[34]

Issues that transpired as a result of the lack of coordination were insufficient logistical support for civilian agency personnel, organizational and cultural differences which led to unfulfilled expectations on both sides, and a lack of surge capability by civilian agencies. Briefly, USAID personnel were unable to get transportation into Haiti; their initial military point of contacts had deployed and left them without domestic contacts. Transportation had not been planned in advance. The military incorrectly assumed that the NGOs on the ground initially would be prepared with comprehensive nation-building programs, whereas the NGOs were surprised that the military was unwilling to accept the responsibility themselves. Finally, the military expected that the civilian agencies would respond as the military does, with reserve personnel ready to be deployed to augment the mission.[35]

In Somalia, food and relief supplies were needed acutely to prevent starvation and accordingly, NGOs arrived to assist with food distribution. In Haiti, many NGOs had been operating in the country for extended periods with their focus on development,

which differed from relief NGOs who operate in crises. Military personnel assumed that since there was a large presence of NGOs already operating in Haiti, they would assist with food distribution, which was not the case. It took approximately a month for the arrival of such NGOs.[36]

Since the end of the Cold War, the U.S. has been involved in a SO every 18 to 24 months, typically lasting about five to eight years. Lessons learned from these operations indicate that SO contribute to global stability and security when effectively designed and conducted. This brief historical review demonstrates that these operations should not be regarded as anomalies, but rather operations that the DoD and other USG Departments and Agencies will continue to engage in to ensure our National Security Strategy is achieved.

Recent legislation and published doctrine have further clarified USG roles in SO. The DoD has defined SO as "…various military missions, tasks, and activities conducted outside the United States in coordination with other instruments of national power to maintain or reestablish a safe and secure environment, provide essential governmental services, emergency infrastructure reconstruction, and humanitarian relief".[37] The immediate goal of SO, as stated in DoDD 3000.05, is to "provide the local populace with security, restore essential services, and meet humanitarian needs."[38] Importantly, this Directive recognizes that SO requires not only an initial response, but also longer-term goals. The interagency nature of SO and the need for a coordinated approach to integrate the efforts of government and NGOs is emphasized as critical to mission success.[39] This is echoed by NSPD-44, which directs all U.S. Departments and Agencies with relevant capabilities, to prepare, plan for, and conduct R&S activities,

coordinated by the DoS, Office of the Coordinator for Reconstruction and Stabilization (S/CRS). The S/CRS was established by then Secretary of State Colin Powell in July of 2004, "to enhance the nation's institutional capacity to respond to R&S operations"; it is the first USG body created purposefully to manage SO.[40]

Current Challenges

Currently, there is emphasis on enhancing USG processes through "soft power" and diplomacy to realize initiatives set forth in the National Security Strategy, utilizing interagency capacity more fully.[41] Most SO occur in complex unstable environments, requiring contributions from a wide range of organizations for success as no single USG entity has all of the necessary relevant expertise. These organizations include military units, USG Departments and Agencies, humanitarian agencies, international organizations, NGOs, and the private sector.[42] However, presently, interagency integration is challenging and requires restructuring to improve responsiveness to crises.

Communication and Integration

A Government Accounting Office (GAO) report (May 2007) summarizes the challenges yet to be overcome to strengthen interagency participation.[43] The report emphasizes that military and civilian efforts must be integrated, but further states that DoD has not provided clear direction to enhance interagency participation. While DoD has established working groups at the Combatant Commands (COCOMs), most of the interagency members assigned to these groups are not experienced planners and function as liaison officers (LNOs), and therefore do not consistently participate in DoD's planning process.[44] Additionally, DoD has restrictions on information sharing, due to

concerns about operations security (OPSEC), making it difficult to conduct appropriate planning in international response efforts and enable a common situational awareness amongst interagency working groups.[45] These limitations have reportedly constrained the COCOM Commanders' ability to achieve unity of effort, or a common understanding of the concept of operations.

Interagency planning is a component of DoDD 3000.05. This Directive represents significant evidence that the military understands, even if not yet fully implemented, that interagency planning and military operations are not isolated events, but must occur concurrently to achieve U.S. goals. Communication across the cultures of interagency partners is one of the constraints in interagency coordination. Diverse backgrounds and training received within the various agencies make it challenging to establish a common language amongst the groups. Although military health professionals have a history of participating in SO, standardized training across the health professionals in the agencies should be formalized.

Legislation, Authorities and Funding

The "Reconstruction and Stabilization Civilian Management Act of 2008" was passed in October 2008 as part of the National Defense Authorization Act (NDAA, PL 110-417, Title XVI) for FY09, granting the authority to the S/CRS, DoS, to provide assistance for R&S crises. The Act allows the S/CRS to create civilian counterparts to the U.S. military who are deployable worldwide to conduct R&S operations in emergent crises, stabilizing failed states or countries transitioning from war to peace. These civilians are employed by eight Federal agencies to include the Departments of Agriculture, Commerce, HHS, Homeland Security, Justice, Treasury, and USAID. As

such, the authority for assistance for an R&S crisis is limited and may only be employed during fiscal years 2009-2011 under the S/CRS; however, the S/CRS has broad bi-partisan support in the current Administration and it is anticipated that there will be significant increases in the President's FY10 budget request.[46,47,48,49]

Section 1207 of the NDAA FY06 (PL 109-163) authorized the Secretary of Defense to transfer up to $100 million for each FY06 and FY07 to the DoS to support R&S operations. This authority was renewed in FY08, section 1210 of NDAA FY08 (PL 110-181). The President requested a new appropriation of $249 million for a Civilian Stabilization Initiative (CSI) in the FY09 budget sent to Congress to support the S/CRS in building the USG interagency civilian expertise. The CSI would allow for building the Active Response Corps (CRC-A) to 250 persons, the Standby Response Corps (CRC-S) and the Civilian Reserve Corps to 2,000 persons, each.[50,51] Of the total CSI budget requested, $75 million has been appropriated to the CRC-A and CRC-S for FY09; the Civilian Reserve Corps was not funded. This is "no-year" funding, thus will not expire until spent.[52]

Although authorization and appropriations are established for the HHS to participate in R&S operations under the S/CRS, current legislation and funding is lacking for other international response situations in which HHS could provide support. Current funding mechanisms established for civilian agencies for international engagements are not adequate to allow appropriate responses by HHS. Most civilian agencies have a domestic focus and therefore, do not have funding or authorities to operate internationally and to obligate their funds beyond their domestic responsibilities.[53,54] As such, this restricts the amount of assistance HHS could

contribute. U.S. Public Health Commissioned Corps officers and HHS civilians are highly qualified public health professionals with extensive expertise and demonstrated leadership in many of the health services areas required in the majority of contingency operations. If they become "internationalized", these officers could make major contributions at the level of a country's Ministry of Health (MoH), providing technical experts, with substantial reach-back capability to home offices within HHS.[55]

Military funding is also constrained in SO. Spending on humanitarian assistance/disaster response by the DoD began increasing in 1996, funded primarily by the Overseas Humanitarian, Disaster, and Civic Aid (OHDACA) Programs, which support the COCOM Commanders' security and cooperation strategies with the following programs: Humanitarian Assistance; Humanitarian Mine Action; Foreign Disaster Relief/Emergency Response; and Building Partnership Capacity.[56,57] OHDACA funds are appropriated by Congress and are relatively limited amounts. For example, in FY08, Congress appropriated $103.3 million for OHDACA funds, distributed as follows: Humanitarian Assistance Program $41 million; Humanitarian Mine Action Program $5 million; and Foreign Disaster Relief/Emergency Response $17 million. The remaining $40 million is set aside to respond to major disasters arising during the year; the amount not spent on such disasters is then transferred to the COCOMs to support additional humanitarian activities. DoD cannot exceed these levels of spending for humanitarian assistance without violating fiscal law or requesting additional appropriations from Congress. Even with Congressional approval of supplemental OHDACA funding, the process is unlikely to be timely for disaster response.

An additional funding mechanism available for the military in SO is the Commander's Emergency Response Program (CERP), which included $977.4 million in FY08. Initially, CERP was funded with millions of dollars recovered in Iraq by U.S. troops; however, these funds were expended quickly. CERP has been appropriated by Congress as part of the NDAA annually since November 2003.[58] CERP provides U.S. government appropriations to commanders at the operational and tactical levels to allow immediate assistance in support of emergency needs of civilians; however, there are some significant limitations to its use. There is a spending ceiling, and expenditures greater than $10,000 require advanced approval at the 0-7/0-8 level. Additionally, for expenditures at this level, it is mandatory to obtain three competitive bids.[59]

Civilian Personnel Management and Logistical Support

Finally, the absence of authorities and thus, appropriations, for HHS to operate internationally makes for difficulties in personnel management and logistical support. Although the U.S. Public Health Service (PHS) Commissioned Corps, much as the U.S. military, receives the Servicemembers' Group Life Insurance (SGLI), they are not covered under the Status of Forces Agreements (SOFA), which specifically mentions military members, but not non-military, uniformed services.

A final challenge is the lack of a logistics chain organic to HHS to support an international engagement. While operating under the S/CRS, HHS receives logistical support from the lead agency, DoS; however, HHS has no infrastructure overseas to maintain logistical support in other international engagements. Therefore, HHS must completely rely on support from other organizations they are working with in support of international response operations.

Recommendations

Communication and Integration

It has been reported that DoD has not achieved consistent interagency representation, and the Joint Interagency Coordination Groups (JIACG) consists of limited numbers of interagency staff, with limited planning experience[60]; however, this seems to be changing. Memorandums of Agreements are currently being finalized between HHS and two of the COCOMS, U.S. Africa Command (AFRICOM) [61] and U.S. Southern Command (SOUTHCOM), to assign an HHS staff LNO. Further, HHS is exploring the insertion of LNOs at the interagency groups in the remaining geographical commands. The goal is to ultimately have two LNOs assigned at each COCOM; one within the interagency group and the other within the Command with the placement to be determined by the various COCOM Commands.

Further, the critique that these LNOs have limited planning experience is likely an indication that domestic agency employees are not trained specifically as planners and lack a history of broad HHS assignments. Currently, HHS does not have a 'planner' qualification or training requirement to fill the LNO positions. To a large extent, the training and qualifications obtained by the LNOs are a result of education and work experience.[62] Additionally, limited HHS assignment experience lessens the LNOs' development of a comprehensive understanding of the larger HHS roles, responsibilities and capabilities and subsequently, limits their reach-back capacity and resources. Clarification by DoD of its requirements for these positions, along with standardization by the Public Health Service for officers who fill these billets (e.g., rank, security clearance, background, education, and training) are required.

To better understand the capabilities available in HHS staff, it is worth examining the National Response Framework (NRF) responsibilities of HHS. According to the DHS, who administers the Framework:

> The *National Response Framework* is a guide that details how the Nation conducts all-hazards response– from the smallest incident to the largest catastrophe. This document establishes a comprehensive, national, all-hazards approach to domestic incident response. The Framework identifies the key response principles, as well as the roles and structures that organize national response. It describes how communities, States, the Federal Government and private-sector and nongovernmental partners apply these principles for a coordinated, effective national response. In addition, it describes special circumstances where the Federal Government exercises a larger role, including incidents where Federal interests are involved and catastrophic incidents where a State would require significant support. It lays the groundwork for first responders, decision-makers and supporting entities to provide a unified national response.[63]

In addition, the NRF includes 15 ESF Annexes, the primary means used to organize Federal resources and provide assistance at the operational level.[64] The ESF Coordinator and Primary Agency for ESF #8, Public Health and Medical Services, is HHS, through its executive agent, the ASPR. Federal assistance is initiated during an emergency or disaster, when local resources are overwhelmed.[65] HHS staff are routinely involved in responding and planning for domestic disasters, which ensures their skills are constantly in use. Considering the wealth of experience available from HHS staff working with ESF #8, there are likely many of these professionals who are extremely experienced domestic emergency responders who may only require additional 'planner' training and HHS assignment experience to effectively fill a COCOM interagency LNO position.

Contending with OPSEC limitations in information sharing between DoD and interagency partners must continue to be a priority. Joint Publication 3-08, (Interagency, Intergovernmental Organization, and Nongovernmental Organization Coordination During Joint Operations Vol I, March 2006), cautions on over classifying information. This publication recommends establishing clear guidelines to avoid over classification, and declassifying information as soon as the situation permits.[66] As much as is possible downgrading information to the least secure level possible by DoD will allow collaboration with interagency partners.

Additionally, to facilitate collaborative information sharing so that DoD may support SO, interagency personnel must have the appropriate security clearances in order to receive classified information. OPSEC training, as part of the standardized core competency training for all interagency partners involved in SO, may further reduce restrictions and concerns by DoD.

To address communication barriers between interagency partners and DoD, standardization of common core SO-related training should be developed and implemented. DoD may address this by creating new designations for military personnel experienced in the interagency environment. The military has specific codes for identifying military occupations. In addition, a military member may be awarded an additional identifier indicating a special skill. In this manner, when a job or deployment arises requiring a particular skill set, these designations make it easier to identify a person with the appropriate background. A new skill identifier should be established to recognize those with interagency training and experience.

Another recommendation to improve communication is to expand the current Air Force Medical Service International Health Specialist (IHS) Program DoD-wide. The Air Force Medical Service IHS Program focuses on developing medical staff with expertise in language, culture and politics. IHS personnel are assigned primarily to the COCOMs, building relationships with partners in countries in their area of responsibility (AOR) to promote stability. They participate in military-to-military and military- to-civilian engagements and exercises in support of COCOM theater engagement plans. Specific skills of the IHS that would prove useful in improving interagency communication and integration across DoD include language; cultural competence; knowledge of medical threats and infrastructure in respective AORs; and an understanding of joint and interagency coordination.[67]

Legislation, Authorities and Funding

In order to exercise international leadership, as suggested in PAHPA, HHS needs new legislation for authorities for international response beyond S/CRS. A study of the interagency coordination of the Joint Interagency Task Force-South (JIATF-S) describes best practices to improve interagency integration.[68] The JIATF-S credits part of its operational success to authorities it holds, assigned by both the President and Congress. These authorities are focused and directly support the JIATF-S mission. Perhaps once a successful track record is established by HHS personnel serving under the S/CRS in R&S operations, this can be leveraged with Congress to expand the HHS role with legislation and new authorities for international response.

The Robert T. Stafford Disaster Relief and Emergency Assistance Act, PL 100-707, signed into law in November 1988 (amended the Disaster Relief Act of 1974, PL

93-288), funds emergency operations of many USG agencies with NRF duties, setting aside contingency funds administered by the Federal Emergency Management Agency (FEMA) for disasters.[69] However, for overseas contingency operations, Congress maintains strict control of funds; a similar funding mechanism, as in the Stafford Act, is only found in humanitarian assistance for the USAID/OFDA. Even so, USAID must still rely on supplemental authorizations to handle emerging situations as most of their funding is earmarked by Congress, leaving little available to readily respond to escalating situations abroad.[70] Additionally, USAID does not have an adequate number of subject matter experts (SME) on staff and therefore must rely on contracting with other agencies, such as HHS and/or its Operating Divisions, to accomplish the work.

The passage of legislation addressing HHS funding for international response mirroring the Stafford Act that currently addresses domestic response would likely result in reducing response delays and supporting the National Security Strategy. This would also commit HHS to a broader international leadership role, as stated in the PAHPA, without negatively affecting its domestic public health and medical preparedness and response programs, for which HHS currently has primary responsibility.

Constraints on military funding for international response include fiscal law and policy prescribed by Congress in Section 404 of U.S. Code, regarding the types of disasters and forms of assistance DoD may respond to and what may be provided. The amount of funding available through OHDACA and CERP are insubstantial relative to USAID's appropriated $2.1 billion, (of which $573.4 million was appropriated to OFDA).[71] This seems logical as DoD is in support of other USG Departments and Agencies in R&S operations; however, there is a need for some flexibility in the

management of DoD funds to ensure timely and effective response, maximizing DoD's unique resources and capabilities with interagency partners.

Civilian Personnel Management and Logistical Support

Currently, the HHS civilian personnel management and logistics systems only provide for domestic deployments as HHS has no overarching authority to operate internationally. For example, DoD requested HHS personnel be assigned to the Combined Security Transition Command–Afghanistan, Command Surgeon, to develop the civil-military health sector. In the absence of authority and appropriations of HHS for international response, DoD funded these personnel, including salary, hazardous duty pay, benefits, retirement, medical evacuation, and even death benefits.[72] These negotiations between DoD and HHS took 18 months. Given that detailing a PHS Commissioned Corps officer to DoD is time consuming and potentially slows down crisis response, having a memorandum of agreement signed between the two organizations prior to the request for support would expedite response.

Similarly, HHS logistical support currently provides only for domestic medical response capability, in support of ESF #8 and the Strategic National Stockpile (SNS). These logistics requirements include responding to the ASPR, the Office of Preparedness and Emergency Response (OPEO), and ultimately, the Office of the Secretary, HHS.[73] HHS logistics personnel are highly trained staff, who function in complex, emergency environments; however, they currently operate only domestically. Once appropriate authorities and appropriations are provided, these personnel would benefit from joint training exercises to develop their international response capabilities.

Conclusion

At present, more attention has been directed by USG leadership to the importance of health as a tool of "soft" power, and the critical need for improving a "whole of government" approach to international response. Evidence of this is found in recent remarks by the Chairman, Joint Chiefs of Staff (CJCS), Admiral Mullen; the Institute of Medicine (IOM) in recommendations on global health investments to the new Administration; and then Senator Hillary Clinton's statements during her nomination process for Secretary of State.[74,75,76]

Admiral Mullen discussed the importance of balancing the tools of national power. Notably for the CJCS, he emphasized that although the military is well-positioned to respond internationally, this is not always the appropriate role for the armed forces. He advised that we must leverage the indispensable participation of all instruments of national power, which include both "soft and hard" power, appropriately balanced.[77]

In recently published IOM recommendations to the new Administration on investments in global health, authored by the Committee on the U.S. Commitment to Global Health, health is described as, "…a highly valued, visible, and concrete investment that has the power to save lives and enhance U.S. credibility in the eyes of the world."[78] The Committee calls for establishing a White House Interagency Committee on Global Health, to increase coordination among departments and agencies working in global health. As indicated by the proposed committee name, interagency collaboration is a vital component of such a highly visible group.

Finally, Secretary Clinton's stated commitment[79] to an overall plan using diplomacy, development and defense, or the 3D's that DoDD 3000.05 intends to integrate, demonstrates the current momentum for strengthening the interagency process and achieving success in R&S operations. Adding the "4th D", or domestic interagency community, as suggested by the U.S. Institute of Peace[80], will further capitalize on the direction of current leadership in the new Administration, and the appreciable gains that may be reached with a "whole of government" approach in international response, critical to promoting stability worldwide.

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